part 2

DENTAL PLAN

The Dental Plan provides benefits for preventive, diagnostic, restorative, and orthodontic dental services. Enrollment in the Dental Plan is optional.

WHO IS ELIGIBLE FOR THE DENTAL PLAN?

Active Employees

All regular employees who work at least 20 hours per week are eligible to participate in the group Dental Plan on the first day of active employment.

Eligible Dependents

The following members of your family are also eligible for Dental Plan coverage:

- Your spouse, defined as the person of the opposite sex to whom you are legally married.
- Your eligible same-sex domestic partner and that partner's eligible child(ren). To be eligible, you must share a committed and exclusive arrangement that meets all of the following criteria:
  - — Both the enrollee and the domestic partner are eighteen years of age or older and unmarried, and
  - — Are of the same sex as each other, and
  - — Are not related by blood in any manner that would prohibit legal marriage, and
  - — Have assumed mutual obligations for the welfare and support of each other (proof of financial interdependence is required), and
  - — Have been sharing a common residence and living together as acouple in the same household for at least twelve months, and
  - — Are each other's sole domestic partner, and neither person has had a different partner less than twelve months before completion of BSA's Affidavit of Domestic Partnership.

Children of your eligible domestic partner must meet the criteria for unmarried children indicated below.

- Your unmarried children up to 19 years of age, including adopted children and stepchildren who are dependent upon you for support. Stepchildren must reside with you to be eligible for coverage. An unmarried child is considered to be eligible for dependent coverage up to his or her 19th birthday.
- Your unmarried children who are mentally or physically incapable of earning their own living may be continued beyond age 19 if, within 31 days after they have reached age 19, you submit proof of the child's incapacity. Coverage may be continued for dependents who are over age 19 and who become mentally or physically incapable of earning their own living while covered as an eligible dependent, by submitting proof of the child's incapacity within 31 days after they become incapacitated.
- Your unmarried children age 19 and over who meet the following criteria:
  - — The dependent child must be the taxpayer's child, including adopted child or stepchild.

— The dependent child must have the same principal residence as the taxpayer for more than one-half of the tax year. Children who are away at school will not be excluded by this criterion as long as when they're not at school, they are living with you. Children of parents who are divorced will not be excluded as long as they are living with one of the parents for at least one-half of the tax year. Please note that stepchildren must reside with you to be eligible.

— The dependent child must not provide more than one-half of his or her own support.

— For a dependent child who is age 19 or over to be eligible for coverage, he or she must attend an accredited college or university on a full-time basis and also meet the criteria indicated above.

Coverage for such unmarried children will end on the earlier of (a) the end of the year of attainment of age 23 or (b) when they no longer meet the criteria indicated above. If they are no longer eligible for coverage because they are no longer attending an accredited college or university on a full-time basis, coverage will end as follows:

— For the Dental Assistance Plan, dependent coverage ends as of the end of the month in which he or she is no longer a full-time student.

— For the CIGNA Dental Care Plan and the CIGNA Dental PPO Plan, dependent coverage ends as of the date he or she is no longer a full-time student.

- Based on the provisions of Michelle's Law, a dependent child who is covered under a group health insurance plan who (1) is enrolled in a post-secondary educational institution and (2) needs to take a medically necessary leave of absence on account of a serious illness or injury from which the child is suffering may be eligible to retain his/her health care coverage while on the medically necessary leave of absence.

  To qualify for the extension of coverage:

  — the child must be enrolled as an eligible dependent under a BSA health care plan,

  — the child must be a full-time student at an accredited college or university immediately before the first day of the medically necessary leave of absence,

  — proof of the leave from the educational institution must be provided to the Benefits Office, and

  — the child's treating physician must provide certification that the child is suffering from a serious illness or injury that necessitates the leave of absence.

  Such coverage can continue until the earlier of:

  — one year from the start of the medically necessary leave of absence or

  — the date on which such coverage would otherwise be terminated under the terms of the health plan.

  In order to be eligible for such benefits, provide proof of the leave from the educational institution and proof of the serious illness from the child's physician to the Benefits Office, Bldg. 400B, within 31 days of the beginning of the medically necessary leave.

If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated in the Qualifying Event section, (1) claims for that dependent will not be eligible for coverage and (2) you will continue paying the premium for coverage until you remove him or her from coverage during an Open Enrollment Period.

ENROLLMENT

Eligible employees may enroll in one of the dental programs within 30 days of their date of hire. Once you enroll, you must continue participation in the program until the end of the calendar year or your termination date of employment, if earlier. If you do not enroll for coverage within 30 days of your date of hire, you will be required to wait until the next Open Enrollment Period or when you have a

Qualifying Event to elect coverage.

To enroll, you must complete an enrollment form and list all dependents you want covered. Enrollment forms are available through the Benefits Office. By completing the form, you will authorize the necessary payroll premiums for the coverage you select. The coverages available are:

- Employee only.
- Employee and one dependent.
- Employee and two or more dependents.

You cannot enroll your eligible dependents without also enrolling yourself for dental coverage nor can you enroll them in a different dental program than the one you select for yourself.

Coverage begins on your date of hire if you complete all enrollment forms and submit them to the Benefits Office within 30 days of your date of hire.

DENTAL PROGRAMS AVAILABLE

Eligible employees and their dependents may enroll in the Dental Assistance Plan, the CIGNA Dental Care Plan, or the CIGNA Dental PPO Plan.

DENTAL ASSISTANCE PLAN

Administered by EBS-RMSCO

The Dental Assistance Plan allows you to use any dentist to care for you and your family. It is a fee-for-service plan and provides reimbursement for a portion of the cost of covered dental services based on a schedule.

Benefits Provided

The Dental Assistance Plan pays a combined maximum of $1,000 in benefits per calendar year for each covered individual for Class I and II services. The maximum lifetime benefit for covered orthodontic services (Class III) is $1,000 per eligible child.

Class I: Preventive and Diagnostic Services

The plan provides coverage for Class I dental services in accordance with a schedule and there is no deductible. Class I expenses include the following:

- Oral examinations (limit of twice per year)
- Prophylaxis: cleaning and scaling of teeth or peridontal prophylaxis (limit of twice per year)
- Fluoride treatments
  - — stannous fluoride (limit of once per year)
- Space maintainers (for insured children under age 19 only)
  - — installation of fixed or removable appliances
  - — subsequent adjustment when required
- X-rays (dental x-rays, radiographs)
  - — full mouth (limit of once every two years)
  - — supplementary bitewing (limit of twice per year)
  - — any dental x-ray required to diagnose a specific condition that needs treatment, except x-rays in conjunction with orthodontia

Class II: Basic and Major Dental Services

Class II services are reimbursed according to a schedule of allowances after each covered individual pays a Deductible consisting of the first $25 in covered expenses during a calendar year. The maximum Deductible for any family is $75 per calendar year. For the family Deductible to apply, at least three family members must reach their individual Deductible. Any covered expenses used to meet the deductible during the last three months of one calendar year may be carried over and applied toward the following year's deductible. Class II services include:

- Restorations: fillings, inlays and crowns
- Oral Surgery: surgical procedures in and about the mouth
- Endodontics (such as root canal work): procedures used for the prevention and treatment of diseases of the dental pulp
- Periodontics: surgical and nonsurgical procedures for treatment of the supporting area around the teeth
- Prosthodontics: services to replace one or more teeth extracted while the patient is covered under the Plan

Class III: Orthodontic Services for Dependent Children

The plan pays 50% of the reasonable and customary charges for covered orthodontic services, subject to a separate $1,000 lifetime maximum benefit per eligible child up to age 19. No deductible is required for orthodontic benefits. The plan does not provide coverage for orthodontic services for adults or children age 19 or older.

Schedule of Maximum Allowable Covered Dental Expenses

The maximum allowable amounts specified in the following schedule are not intended to represent what your dentist's charges will be or should be. These are the maximum reimbursement amounts for specified dental services. The claims administrator will pay benefits for dental services that are covered by the plan but not listed below. The claims administrator will determine benefits on the basis of the complexity and severity of the type of service in an amount consistent with the maximum allowance specified for other dental services. Limitations may apply.

Dental Service Number	Class I: Preventive and Diagnostic Services (Not Subject to Deductible)	Maximum Allowable
0120	Periodic oral examination (no more than two in any calendar year)	$22
0210	X-rays — complete series (once every two years)	$50
0270	Bitewing x-rays — single film	$10
	Prophylaxis with or without oral examination (two treatments per calendar year):	
1110	Individuals 14 years of age or older	$38
1120	Individuals under 14 years of age	$25
1221	Topical application of stannous fluoride (one treatment per calendar year)	$30

Class II: Basic and Major Dental Services (Subject to Calendar Year Deductible)

2110	Amalgam fillings — deciduous teeth, one surface	$ 26
2140	Amalgam fillings — permanent teeth, one surface	$ 26
2752	Crowns — porcelain fused to metal	$225
3320	Root canal therapy - two canals	$225
4341	Periodontal scaling and root planing - per quadrant	$ 45
7110	Simple extractions — first tooth	$ 37
9210	Anesthesia - local	$ 23
9225	Anesthesia - general	$ 97

Class III — Children's Orthodontic Services (Not Subject to Deductible)

8000 series	50% of Reasonable and Customary Charges Limitations may apply.

Coverage information indicated is not all inclusive. A copy of the schedule of benefits can be obtained at no cost through the Benefits Office.

Predetermination of Benefits

Predetermination of Benefits under the Dental Assistance Plan allows you to determine what services will be covered and what payments will be made before your dental treatment is performed. The procedure is as follows:

- The dentist informs the claims administrator of the proposed course of treatment by itemizing services and charges on the claim form which you provide.
- The claims administrator then determines the amount the plan will pay and informs you and your dentist. You and your dentist should discuss the result before the work is done.

If a Predetermination of Benefits is not requested, the claims administrator will pay the claim based on the information provided.

If your dentist submits a treatment plan for Predetermination of Benefits and then changes the treatment plan, the claims administrator will adjust the payments accordingly. If any major changes in the treatment plan are made, your dentist should send in a revised course of treatment to the claims administrator.

Alternative Procedures

Sometimes there are several possible ways to treat a particular dental problem. The claims administrator will base payment on the least costly scheduled amount, provided the result meets acceptable dental standards.

If you and your dentist decide to proceed with a more costly treatment, you will be responsible for the charges beyond those for the least costly appropriate treatment.

Services Provided After Eligibility Ceases

Normally, the Dental Assistance Plan will not pay for services or supplies beyond termination of your coverage or when a dependent is no longer eligible for coverage, even if a Predetermination of

Benefits has been made before coverage ceases. However, there are three exceptions for which benefits are payable, provided the work is completed within 60 days after coverage terminates:

- A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the patient was covered
- A crown if the dentist prepared the tooth for the crown while the patient was covered by the plan
- Root canal therapy if the dentist opened the tooth while the patient was covered

Coordination of Benefits

Coverage Under Other Employers' Plans

If you or your covered dependents are eligible to receive benefits under another group dental plan, the benefits from that plan will be coordinated with the benefits from the Dental Assistance Plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

In the case of dependent children who are covered by more than one group plan, the insurance plan of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Medical Plan

The Medical Plan, specifically the OAP medical program, administered by CIGNA, covers a limited number of specific dental procedures. When dental benefits are available under both the OAP medical program and the Dental Assistance Plan, the benefits payable under the Dental Assistance Plan will be coordinated with the benefits payable under the OAP medical program so that up to 100% of allowable expenses will be paid jointly by the plans. In all such cases, the OAP medical program is considered the primary policy to which you must submit claims first.

Claims

How to File a Claim

You have the following options to file a claim under the Dental Assistance Plan.

- Your dentist can submit the claim electronically
- Your dentist can send a computerized printout
- You can send a computerized printout
- You can send an itemized bill

All claims should be sent to the address on your identification card

EBS-RMSCO, Inc.
P.O. Box 778
Liverpool, NY 13008-0778

When submitting claims, please be sure to include a photocopy of your identification card and staple it to the bill.

Questions About Claims

If you have a question about your Dental Assistance Plan claim, you should contact the claims administrator at EBS-RMSCO at (888) 225-0522. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received.

How to Appeal a Claim

Your explanation of benefits will identify if a claim is denied and the reason for the denial. You may request a review of the denied claim in writing to EBS-RMSCO at P.O. Box 778, Liverpool, NY 13008-0778 within 60 days of the receipt of the notice of denial. You should state the reasons why you feel your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, a decision will be rendered within 60 days of the date your request for review is received. In special cases requiring a delay, a decision will be made no later than 120 days after your request for review is received.

Phone Number

EBS-RMSCO: (888) 225-0522

CIGNA DENTAL CARE PLAN

The CIGNA Dental Care Plan provides services through a network of participating dentists. It is a dental maintenance organization, DMO, and services are based on a fee schedule. If you choose to participate in this plan, you must select a participating dentist. You may select different participating dentists for you and your dependents. By contacting CIGNA, you may change participating dentists as of the first day of the month after you request the change. Coverage is not provided for providers who are not in the CIGNA DMO network. If you require the care of a dental specialist, your participating dentist must give you a referral to a specialist in CIGNA's DMO network.

Benefits Provided

The CIGNA Dental Care Plan provides coverage for preventive, basic and restorative dental services, and orthodontia for both adults and children. Some of the services that are currently provided are as follows:

Preventive and Diagnostic Care	Your Cost
Oral examinations (periodic)	$0
X-rays complete series including bitewings (limit of one every three years)	$0
Bitewing x-rays (single film)	$0
Prophylaxis - routine cleaning (limit of one every six months)	$0
Topical application of fluoride, up to 19th birthday (limit of one every six months)	$0

Basic Restorative Care	Your Cost
Amalgam fillings - 1 or more surfaces (primary or permanent)	$5
Resin-based composite (anterior) - 1 surface	$5
Resin-based composite (anterior) - 2 surfaces	$10
Resin-based composite (anterior) - 3 surfaces	$15
Resin-based composite (anterior) - 4 or more surfaces	$75
Resin-based composite (posterior) - 1 surface	$40
Resin-based composite (posterior) - 2 surfaces	$50
Resin-based composite (posterior) - 3 surfaces	$70
Resin-based composite (posterior) - 4 or more surfaces	$95

Major Restorative Care	Your Cost
Crown - porcelain/ceramic substrate	$435
Crown - porcelain fused to high noble metal	$400
Crown - porcelain fused to noble metal	$380
Anterior root canal (permanent tooth excluding final restoration)	$230
Bicuspid root canal (permanent tooth excluding final restoration)	$270
Molar root canal (permanent tooth excluding final restoration)	$370
Periodontal scaling and root planing - 1 to 3 teeth (limit 4 quadrants per consecutive 12 months)	$50
Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$10
Surgical extraction erupted tooth (removal of bone and/or section of tooth)	$70
Anesthesia - general (first 30 minutes)	$145
Anesthesia - intravenous conscious sedation (first 30 minutes)	$145

Orthodontia	Your Cost
Periodic orthodontic treatment visit (as part of a contract)	
— Children (up to 19th birthday) - 24 month treatment fee	$1900
- charge per month for 24 months	$79.17
— Adults - 24 month treatment fee	$2500
- charge per month for 24 months	$104.17

Coverage information indicated is not all inclusive. Please note that the cost of dental services is subject to change and is based on provisions of the CIGNA Dental Care Plan at the time the service is provided. The cost of other dental services covered by the CIGNA Dental Care Plan are included in the CIGNA Dental Care patient charge schedule which can be obtained at no cost through the Benefits Office or directly from CIGNA.

Emergency Services

CIGNA will pay for up to $50 in dental expenses for each emergency if (1) the need for treatment occurs at least 50 miles from the participant's home or (2) the participant is unable to contact the designated participating dentist. Emergency treatment must not be received in a hospital and must be performed during regular office hours. If emergency services are performed after regular office hours, a fee will be charged.

Emergency means diagnostic and palliative procedures administered in the case of an emergency which involves acute pain and a condition which requires immediate treatment but does not produce a definitive cure.

Specialty Referrals

When specialized dental care services are required, your designated participating dentist must initiate the referral process and refer you to a specialist in CIGNA's DMO network.

Coordination of Benefits

If you or any of your covered dependents are eligible to receive benefits under another group dental plan, benefits from that plan will be coordinated with the benefits from the CIGNA Dental Care Plan.

How to File a Claim

There are no claim forms to file under the CIGNA Dental Care Plan. You just pay the dentist the scheduled fee.

Questions About Claims

If you have any questions about costs or procedures under the CIGNA Dental Care Plan, you should contact CIGNA at (800) 367-1037.

How to Appeal a Claim

You may request a review of the denied claim in writing to CIGNA Dental Health, Central Region, 6600 Campus Circle Drive East, Suite 100, Irving, TX 75063 or by telephone to the CIGNA Dental Care Plan. You should state the reasons why you feel your claim should not have been denied. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Phone Number

CIGNA Dental Care Plan: (800) 367-1037

Provider Directory

Provider directories are available at no charge in the Benefits Office or on the Web at: www.cigna.com

CIGNA DENTAL PPO PLAN

Under the CIGNA Dental PPO Plan, services are provided through a network of participating dentists, but benefits are also provided for use of providers who are not in the network. You do not need to enroll with a specific dentist to receive coverage under this plan. In-network benefits are provided if you use a provider in CIGNA's dental PPO network. Out-of-network benefits are provided if you use a provider who is not in CIGNA's dental PPO network. The plan is a preferred provider organization, PPO, and provides reimbursement for a portion of the cost of covered dental services based on a schedule. To receive reimbursement of covered expenses, you must submit a claim form.

Benefits Provided

The CIGNA Dental PPO Plan provides coverage for preventive, basic and restorative dental services, and orthodontia for children. The combined in- and out-of-network maximum calendar year benefit for each covered individual for Class I, II and III services is $1,000. The maximum lifetime benefit for covered orthodontic services, Class IV, is $1,000 per eligible child.

Class I: Preventive and Diagnostic Care

Covered in-network expenses are reimbursed at 80% of the Reasonable and Customary amount. Covered out-of-network expenses are reimbursed at 70% of the Reasonable and Customary amount. No deductible is required for Class I services.

Class I expenses include:

- Oral examination (limit of 2 per person per calendar year)
- X-rays - complete series (limit of once per person in any 3 calendar years)
  - — Bitewing (limit of twice per person per calendar year)
  - — Panoramic (limit of once per person in any 3 calendar years)

- Prophylaxis: cleaning (limit of twice per person per calendar year)
- Topical application of fluoride (excluding prophylaxis) - limited to persons less than 19 years old (limit once per person per calendar year)
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old (limit of once per tooth in any 3 calendar years)
- Space maintainers, fixed unilateral (limited to non-orthodontic treatment)

Class II: Basic Restorative Care

Covered in-network expenses are reimbursed at 60% of the Reasonable and Customary amount after each covered person meets the Deductible. Covered out-of-network expenses are reimbursed at 45% of the Reasonable and Customary amount after each covered person meets the Deductible.

Class II expenses include:

- Amalgam filling
  - — Primary (baby) teeth, one surface
  - — Permanent teeth, one surface
- Composite/resin filling, one surface
- Root canal therapy, including x-ray, test, laboratory exam or follow-up care that is part of the root canal therapy and not a separate dental service
- Osseous surgery - (If more than one periodontal surgical service is performed per quadrant only the one with the largest maximum covered expense is a dental service)
- Periodontal scaling and root planing (entire mouth)
- Adjustments - within 6 months of installation of a complete denture
- Re-cement bridge
- Simple extractions
- Surgical removal of erupted tooth, or impacted tooth (soft tissue, partially bony, or completely bony)
- Local anesthetic for extractions and other oral surgery

Class III: Major Restorative Care

Covered in-network expenses are reimbursed at 50% of the Reasonable and Customary amount after each covered person meets the Deductible. Covered out-of-network expenses are reimbursed at 35% of the Reasonable and Customary amount after each covered person meets the Deductible.

Class III expenses include:

- Crowns
- Fixed or removable appliances (complete dentures, upper or lower)
- Partial dentures
- Bridge pontics
- Abutment crowns

Class IV: Children's Orthodontia

For covered in-network and out-of-network orthodontic expenses per covered child up to age 19, the Plan pays 50% of the Reasonable and Customary amount after each child meets the Deductible. There is a separate combined in- and out-of-network maximum lifetime benefit of $1,000 for each covered child for Class IV services. The plan does not provide coverage for orthodontic services for adults or children age 19 or older.

Class IV services include:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and active treatment and retention appliances
- Fixed or removable appliances (limit of one appliance per person)

Coverage information indicated is not all inclusive. A copy of the schedule of benefits can be obtained at no cost through the Benefits Office.

Deductible

The CIGNA Dental Care Plan Deductible is the first $25 in covered expenses per person during a calendar year. The maximum Deductible for any family is $75 per calendar year. For the family Deductible to apply, at least three family members must reach their individual Deductible. Covered expenses incurred for in-network and out-of-network providers will be combined and used to satisfy the Deductible required for Class II, III, and IV services. There is no deductible for Class I services.

Coordination of Benefits
Coverage Under Other Employers' Plans

If you or your covered dependents are eligible to receive benefits under another group dental plan, the benefits from that plan will be coordinated with the benefits from the CIGNA Dental PPO Plan so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid jointly by the plans.

An allowable expense is any necessary, reasonable, and customary expense covered in full or in part under any one of the group plans involved.

In the case of dependent children who are covered by more than one group plan, the insurance plan of the parent whose birthday occurs earlier in the calendar year will be the primary insurance plan for the children.

To obtain all the benefits available, you and your family members must file claims under each plan.

Claims
How to File a Claim

To file a claim under the CIGNA Dental PPO Plan, you must complete a Dental PPO Group Dental claim form which is available in the Benefits Office or on the Web at:

www.bnl.gov/HR/Benefits/dental.asp

When you or a covered member of your family goes to the dentist, you must complete Part 1 of the claim form according to the instructions on the form. The dentist will complete Part 2. Part 1 includes:

- Authorization for the dentist to release necessary information to the claims administrator so that your claim may be processed. This authorization must be signed as described on the form.
- Authorization for the claims administrator to pay the dentist directly for work performed for you and members of your family. If you do not assign payment directly to your dentist, payment of benefits will be made to you.

Completed claim forms should be sent by you or your dentist to the address on the claim form.

Questions About Claims

If you have a question about your CIGNA Dental PPO Plan claim, you should contact CIGNA at (888) 336-8258. When discussing your claim, please refer to the explanation of benefits, the claim form, and any other correspondence that you may have received.

How to Appeal a Claim

Your explanation of benefits will identify if a claim is denied. You may request a review of the denied claim in writing to the insurance company within 365 days of the receipt of the notice of denial. You should state the reasons why your claim should not have been denied, including any additional documents which you believe support your claim. In normal cases, the insurance company will render a decision within 30 days of the date your request for review is received.

Phone Number

CIGNA Dental PPO Plan: (888) 336-8258

Provider Directory

Provider directories are available at no charge in the Benefits Office or on the Web at:
www.cigna.com

DUAL COVERAGE

Prior to January 1, 2006, dual coverage allowed both spouses to participate in the EBS-RMSCO program where they could elect to cover each other and their eligible dependents provided they paid the required premiums. Dual coverage was eliminated as of January 1, 2006. This change does not apply to members of the IBEW union; although, IBEW members who did not have dual coverage on December 31, 2005 may not elect it.

EXCLUSIONS

The following dental expenses are not covered by the Dental Assistance Plan, the CIGNA Dental Care Plan, or the CIGNA Dental PPO Plan:

- Cosmetic treatment, experimental treatment, dietary planning, plaque control, oral hygiene instructions, treatment for the correction of any congenital or developmental malformation.
- Replacement of a lost or stolen appliance, extra appliances, or a dentally acceptable bridge, cap, crown, or denture.
- Replacement of a bridge, denture, cap, crown, etc. within five years of its original installation unless this is necessary owing to installation of an original opposing full denture, the extraction of natural teeth, or irreparable damage as a result of an accident while the denture is in place.
- Replacement of a fixed or removable prosthodontic or orthodontic appliance that has been made useless due to patient abuse, misuse, or neglect, or has been lost, stolen, or damaged.
- Appliances or restorations to alter vertical dimensions, stabilize teeth, restore occlusion, or diagnose or treat conditions or dysfunction of the temporomandibular joint.
- Installation of an initial appliance replacing teeth that were already missing when you or a dependent became insured.
- Any procedure or service associated with the placement or prosthodontic restoration of a dental implant.
- Services related to an injury or illness paid under Workers' Compensation, no-fault automobile or uninsured motorist insurance law, government laws, regulations, public programs, or similar laws.

- Charges in excess of Reasonable and Customary limits.
- Charges for unnecessary services or charges which would not have been made had no benefit existed or which you would not be legally required to pay.
- Services covered by a group medical plan.
- Prescription drugs.
- Administration of sedation or a general anesthesia (Exclusions apply under the CIGNA Dental Care Plan and the CIGNA Dental PPO Plan).
- Charges for broken appointments or for completion of claim forms.

Additional exclusions may apply. Contact the Benefits Office at (631) 344-2877 or (631) 344-5126 for additional information, including a copy of the dental schedules.

EMPLOYEE PREMIUMS

Employees and participants receiving BSA Long Term Disability Plan benefits who elect to participate in the Dental Plan must pay the required premiums. Your premiums are based on the Plan you elect and whether you elect to cover (a) yourself only, (b) yourself and one dependent or (c) yourself and two or more dependents. You may pay your premiums with before-tax or after-tax dollars. Before-tax premiums are deducted from your pay before state and federal income taxes and Social Security taxes are withheld, resulting in a lower actual cost to you. After-tax premiums are deducted from your pay after taxes are withheld and result in no tax savings to you.

If your annual salary is below the Social Security wage base and you pay your premiums with before-tax dollars, your future Social Security benefits may be reduced.

Employee premiums are indicated at the end of the Dental Plan section.

OPEN ENROLLMENT PERIOD

Open enrollment is held once a year. During an Open Enrollment Period, you may change dental programs, drop coverage and/or add or drop dependents from your coverage. Employees who did not previously elect dental coverage may elect it during the Open Enrollment Period. Changes you elect during the Open Enrollment Period will be effective January 1 of the following calendar year. Your elections will be in effect for the remainder of the calendar year unless you notify the Benefits Office of a Qualifying Event within a limited period of time from the date of the event.

QUALIFYING EVENT

A Qualifying Event is a change in your family status and includes:

(a) Change in legal marital status
   1. marriage
   2. death of spouse
   3. divorce
   4. legal separation
   5. annulment

(b) Change in the number of dependents
   1. birth
   2. adoption
   3. placement for adoption
   4. death of a dependent

(c) Change in employment status
   1. termination or commencement of employment of the employee, spouse or dependent (other than for misconduct)

(d) Changes in work schedule
   1. an increase or decrease in the number of hours of employment by the employee, spouse or dependent
   2. a switch between full-time and part-time status
   3. a strike or lockout
   4. commencement or return from an unpaid leave of absence

(e) The dependent satisfies or ceases to satisfy the requirements for unmarried dependents
   1. attainment of age
   2. student status

(f) A change in the place of residence or work site of the employee, spouse or dependent

In addition, based on the provisions of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), employees and dependents that are eligible but not enrolled for BSA health insurance plan coverage may enroll for coverage if one the following conditions is met:

- The employee or dependent loses eligibility and is terminated from Medicaid or CHIP* coverage or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP*.

*CHIP (Children's Health Insurance Program) is a state program designed to provide health care coverage for uninsured children and some adults.

You have 31 days from the date of a Qualifying Event to make changes to your dental coverage for all items indicated above except (a)(3), (a)(4), (e)(1), (e)(2), and changes related to CHIPRA. You have 60 days from the date of a Qualifying Event to make changes to your dental coverage for items (a)(3), (a)(4), (e)(1) and (e)(2). The change requested must relate to the change in your family status that affects eligibility for dental coverage. Changes are made by completing an enrollment form, available in the Benefits Office. The completed form must be submitted, with proof of the Qualifying Event, to the Benefits Office. Your premiums will then be changed for the remainder of the calendar year. Coverage will become effective as of the date of the event.

If you do not make a change to your dental coverage within the applicable period indicated above, you must wait until the next Open Enrollment Period. If a dependent is no longer eligible for coverage and you do not remove that dependent from your coverage within the applicable period indicated above, (1) claims for that dependent will not be eligible for coverage and (2) you will continue paying the premium for coverage until you remove him or her from coverage during an Open Enrollment Period.

MISCELLANEOUS

General Information

Information regarding the plan identification number, plan year, plan funding, type of plan, plan sponsor, plan administrator, agent for legal process, your rights under ERISA, prudent actions by plan fiduciaries, modification, suspension, or termination of the plan, and privacy of information can be found in the General Information section of this booklet.

Leave of Absence

If you are on an approved Leave of Absence, including for military duty, you may continue your dental coverage during the term of the approved leave from the starting date of your leave by paying the required active employee premiums. This coverage will cease when the employee is no longer on the approved Leave of Absence. Participants on approved military leave may drop dental coverage for themselves while continuing to cover their dependents.

Continuation of insurance is not allowed while on leave for other employment when (1) the other employer offers coverage or (2) the other employer is an agency or prime contractor of the federal government that will cover you under its insurance program.

If you drop dental coverage while on an approved Leave of Absence, you may enroll again upon your return to work in an eligible status.

Participants Receiving Long Term Disability Benefits

Employees who qualify for Long Term Disability (LTD) Plan benefits may continue dental coverage for themselves and their eligible dependent(s) by payment of the required active employee premiums. This coverage will cease when the employee is no longer eligible to receive LTD Plan benefits.

Reasonable and Customary (R&C)

Under the CIGNA Dental PPO Plan, a charge is considered Reasonable and Customary if it is the normal charge made by the provider for a similar service or supply and it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CIGNA.

Termination of Coverage

Dental coverage for active employees, participants receiving LTD Plan benefits, and their dependents under the Dental Plan will cease on the earlier of the date your employment terminates, the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums. Coverage for terminated employees, who continue benefits under COBRA, will cease on the earlier of the date you elect to drop such coverage, the date you are no longer eligible for coverage, or when you fail to pay the required premiums.

Individual dependent coverage will also cease when the dependent becomes ineligible. Coverage for your spouse also ceases due to divorce or legal separation from you. Coverage for your dependent children also ceases when the child no longer meets the eligibility requirements of this plan.

COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Benefits Office of the qualifying event.

Notification Requirements

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Office in writing within 60 days after the qualifying event occurs and provide documentation of the event.

When the Benefits Office has been notified that one of these events has occurred, they will in turn notify you and your dependents of the right to elect continuation coverage.

If you do not elect continuation coverage within 60 days from the date of loss of coverage due to one of the events described above, your group dental insurance coverage will end retroactively to the date of the event that caused the loss of coverage.

If you elect continuation coverage, you will have the same dental coverage you had before the event, although it may be modified if coverage changes for similarly situated participants.

How is COBRA Coverage Provided?

Once the Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage

generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefits Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Benefits Office within 60 days after the qualifying event occurs and provide documentation of the event.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Premium Requirements

You, or your dependents, will be required to pay 102% of the full cost of the continuation coverage under the provisions of COBRA. You will be billed for the required premium on a regular basis. COBRA premiums are indicated at the end of the Dental Plan section.

Termination of Coverage Under COBRA

Continuation coverage will end when any of the following events occur:

- The Benefits Office is notified by you or your dependent to discontinue coverage.
- 18 months after continuation coverage begins (if coverage was continued due to termination or resignation of the employee).
- 29 months after continuation coverage begins (if coverage was continued due to disability).
- 36 months after continuation coverage begins (if coverage was continued because of death of the employee, divorce, legal separation or loss of dependent status).
- The individual becomes eligible for Medicare after the date of the COBRA election.
- An individual becomes covered under another group plan, unless a pre-existing condition prevents you or your dependent from being covered by the other plan.
- For a spouse or dependent child: If the Benefits Office is not notified within 31 days of the date of divorce or legal separation.
- For a dependent child: If the Benefits Office is not notified within 31 days of the date the dependent status ends.
- Payment for continuation coverage is not paid on time.
- The group health care plan is terminated for active employees.

CONVERSION

If you were enrolled in the CIGNA Dental Care Plan or the CIGNA Dental PPO Plan immediately prior to when coverage ceased and (a) coverage ceased because you were no longer in active employment or (b) coverage ceased due to ineligibility, you and your dependents may be entitled to convert your

group dental insurance coverage to a policy directly with CIGNA to the CIGNA Dental Care Plan. If you qualify for the conversion, you must apply in writing and pay the required premium for the coverage to CIGNA within 31 days from the date your group insurance coverage ceased. The necessary application forms are available directly from CIGNA.

If you were enrolled in the Dental Assistance Plan conversion coverage is not available.

ERISA

Refer to the General Information section of this booklet for information regarding your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

EMPLOYEE PREMIUMS
(January 1, 2009)

Coverage	Dental Assistance Plan (EBS-RMSCO) or CIGNA DMO		CIGNA PPO	
	Weekly	Monthly	Weekly	Monthly
Employee only	$1.13	$ 5.00	$2.33	$10.11
Employee + 1 dependent	$2.26	$10.00	$4.81	$20.86
Employee + 2 or more dependents	$4.30	$19.00	$7.90	$34.23

COBRA PREMIUMS
(January 1, 2009)

Coverage	Monthly Premium		
	Dental Assistance Plan (EBS-RMSCO)	CIGNA DMO	CIGNA PPO
Employee only	$21.80	$23.85	$41.93
Employee + 1 dependent	$46.32	$48.46	$89.07
Employee + 2 or more dependents	$64.94	$72.11	$124.92

These premiums are subject to change.